Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Justice and Public Safety

February 19, 2019

[redacted]

Dear [redacted]:

Re: Your request for access to information under Part II of the Access to Information and Protection of Privacy Act [JPS/16/2019]

On February 15, 2019, the Department of Justice and Public Safety (JPS) received your request for access to the following records:

> **"The report "Newfoundland and Labrador Corrections and Community Services: Deaths in Custody Review" was released Feb. 6. I request an unredacted copy of that report. If redactions are deemed required under the Access to Information and Protection of Privacy Act (ATIPPA), please cite reasons, with reference to exceptions as listed in the Act."**

Please be advised that a decision has been made by the Deputy Minister of JPS to provide access to some of the requested information. However, access to the remainder of the information/records has been refused in accordance with the following exceptions to disclosure, as specified in the Access to Information and Protection of Privacy Act (the Act):

> 31. (1) The head of a public body may refuse to disclose information to an applicant where the disclosure could reasonably be expected to
> (a) interfere with or harm a law enforcement matter;
> (l) reveal the arrangements for the security of property or a system, including a building, a vehicle, a computer system or a communications system;
>
> 40. (1) The head of a public body shall refuse to disclose personal information to an applicant where the disclosure would be an unreasonable invasion of a third party's personal privacy.

As required by 8(2) of the Act, we have severed information that is unable to be disclosed and have provided you with as much information as possible. In accordance with your request for a copy of the records, the appropriate copies have been enclosed.

Please note that pages 10-41 have been withheld in their entirety under s.40(1), while some information on the following pages has also been withheld under s.31(1)(a) and s.31(1)(l) as well – 23, 33, 37 and 38.

The Access to Information and Protection of Privacy Act requires us to provide an advisory response within 10 days of receiving the request. As this request has been completed prior to day 10, this letter also serves as our Advisory Response.

Please be advised that you may ask the Information and Privacy Commissioner to review the processing of your access request as set out in section 42 of the *Act* (a copy of this section of the Act has been enclosed for your reference). A request to the Commissioner must be made in writing within 15 business days of the date of this letter or within a longer period that may be allowed by the Commissioner.

The appeal may be addressed to the Information and Privacy Commissioner as follows:

Office of the Information and Privacy Commissioner
2 Canada Drive
P. O. Box 13004, Stn. A
St. John's, NL. A1B 3V8

Telephone: (709) 729-6309
Toll-Free: 1-877-729-6309
Facsimile: (709) 729-6500

You may also appeal directly to the Supreme Court Trial Division within 15 business days after you receive the decision of the public body, pursuant to section 52 of the *Act* (a copy of this section of the Act has been enclosed for your reference).

Please be advised that responsive records will be published following a 72 hour period after the response is sent electronically to you or five business days in the case where records are mailed to you. It is the goal to have the responsive records posted to the Completed Access to Information Requests website within one business day following the applicable period of time. Please note that requests for personal information will not be posted online.

If you have any questions please contact me by telephone at 709-729-7128, or by email at sonjaelgohary@gov.nl.ca.

Sincerely,

Sonja El-Gohary
ATIPP Coordinator

Access or correction complaint

42. (1) A person who makes a request under this Act for access to a record or for correction of personal information may file a complaint with the commissioner respecting a decision, act or failure to act of the head of the public body that relates to the request.

(2) A complaint under subsection (1) shall be filed in writing not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16 (2).

(3) A third party informed under section 19 of a decision of the head of a public body to grant access to a record or part of a record in response to a request may file a complaint with the commissioner respecting that decision.

(4) A complaint under subsection (3) shall be filed in writing not later than 15 business days after the third party is informed of the decision of the head of the public body.

(5) The commissioner may allow a longer time period for the filing of a complaint under this section.

(6) A person or third party who has appealed directly to the Trial Division under subsection 52 (1) or 53 (1) shall not file a complaint with the commissioner.

(7) The commissioner shall refuse to investigate a complaint where an appeal has been commenced in the Trial Division.

(8) A complaint shall not be filed under this section with respect to

(a) a request that is disregarded under section 21 ;

(b) a decision respecting an extension of time under section 23 ;

(c) a variation of a procedure under section 24 ; or

(d) an estimate of costs or a decision not to waive a cost under section 26 .

(9) The commissioner shall provide a copy of the complaint to the head of the public body concerned.

Direct appeal to Trial Division by an applicant

52. (1) Where an applicant has made a request to a public body for access to a record or correction of personal information and has not filed a complaint with the commissioner under section 42 , the applicant may appeal the decision, act or failure to act of the head of the public body that relates to the request directly to the Trial Division.

(2) An appeal shall be commenced under subsection (1) not later than 15 business days

(a) after the applicant is notified of the decision of the head of the public body, or the date of the act or failure to act; or

(b) after the date the head of the public body is considered to have refused the request under subsection 16 (2).

(3) Where an applicant has filed a complaint with the commissioner under section 42 and the commissioner has refused to investigate the complaint, the applicant may commence an appeal in the Trial Division of the decision, act or failure to act of the head of the public body that relates to the request for access to a record or for correction of personal information.

(4) An appeal shall be commenced under subsection (3) not later than 15 business days after the applicant is notified of the commissioner’s refusal under subsection 45 (2).

Newfoundland and Labrador Corrections and Community Services: Deaths in Custody Review

December 12, 2018

December 12, 2018

The Honourable Andrew Parsons
Minister of Justice & Public Safety, Attorney General
Government of Newfoundland & Labrador

Dear Minister:

I am pleased to submit the report, ***Newfoundland and Labrador Corrections and Community Services: Deaths in Custody Review***. The report reviews as mandated, the circumstances surrounding four institutional deaths. These are specifically the deaths of Douglas Neary, Skye Martin, Samantha Piercey, and Christopher Sutton that occurred between August 31, 2017 and June 30, 2018. As requested, the review included Adult Corrections response to, and the appropriateness of, the related corrections policies and procedures. The report contains recommendations on how we believe the current system can be improved.

The Review Team, including Robert St. Croix and Michelle Hawco, have visited five correctional facilities within the province and the Forensic Psychiatric Unit of the Waterford Hospital. Further, the Review Team has interviewed many current and former staff members, inmates, ex-inmates, family members, service providers and other stakeholders. I am extremely appreciative of the frankness of all whom provided valuable insight and feedback during this review.

The implementation of the recommendations contained in this report will improve the delivery of services and practices within Adult Custody in Newfoundland and Labrador.

Respectfully,

_____
Marlene Jesso
Superintendent (retired), RNC

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Executive Summary

The safety and well being of inmates and correctional staff in the province's adult correctional facilities is critical to the successful custody and rehabilitation of adult offenders. The Mission Statement of Corrections and Community Services is as follows:

> To provide an integrated and supportive service to those who engage in or have been affected by crime. We foster recovery, rehabilitation, and reintegration for the benefits of victims; adults; and youth involved with the criminal justice system; families and communities.

In April 2018, the sudden death of Skye Martin, an inmate at the Newfoundland and Labrador Correctional Centre for Women (NLCCW) prompted questions regarding the adequacy of the care provided to individuals in custody who are or may need mental health services. In May 2018, the Hon. Andrew Parsons, Q.C., Minister of Justice and Public Safety and Attorney General for Newfoundland and Labrador, commissioned an independent external review of the circumstances surrounding the death of the individual. The review was led by retired RNC Superintendent Marlene Jesso, whose specific mandate was to examine staff response to the situation along with the appropriateness of related corrections policies and procedures with a view to providing recommendations to improve the service delivery of correctional services in the province where appropriate.

Shortly after commissioning the review, the mandate was expanded to cover four sudden deaths which occurred between August 31, 2017 and June 30, 2018 at two of the province's facilities. Two additional team members, Robert St. Croix and Michelle Hawco, were added to support its expanded mandate.

Over the course of the review, the Review Team spoke to family members where available, to hear their concerns. The Review Team considered all institutional documents provided by officials in relation to the four individuals. Access was provided to documentation including files and correctional notes, and access to correctional staff and

officials of the Department of Justice and Public Safety. Interviews have been conducted with staff, inmates, medical care providers and community agencies including Stella's Circle, Turnings, the Canadian Mental Health Association and the John Howard Society. The Review Team spoke to the Office of the Citizens' Representative who has investigated various issues in the corrections system. The team visited other institutions in the province and also reviewed secondary sources such as relevant articles and reports from other jurisdictions in Canada.

This is not the first time an external review has been commissioned to examine issues including deaths within the adult prison system in the province. In 2008, the report *Decades of Darkness* provided an independent assessment of the status of the prison system, which included 77 recommendations for change. In addition, there have been at least two independent reviews into sudden deaths which occurred at Her Majesty's Penitentiary (HMP). The first was a judicial inquiry in 1993 into the death of Michael Simon, Jr., and the second was a report in 2009 on the death of Austin Aylward, Jr. While the Review Team does not intend to revisit these reports, the fact that many of the issues identified in these reports continue to arise within the prison system cannot be ignored. Outstanding issues include modernization of the legislation, shifting from a static to a dynamic security model, physical improvements to facilities, expansion of program delivery, and improved communication and information sharing.

While the mandate did not specifically include an examination of mental health services, it became clear that the issues in the prison system are contributing to the poor mental health of inmates. A lack of physical space to house inmates makes it difficult to meet the security and health needs of inmates. Programming is limited as there are insufficient resources, including space and facilitators. Many factors were identified that make it difficult for correctional staff to assess and respond to mental health needs. For example, once a person is incarcerated or an inmate returns to prison after a hospital stay, information sharing, specifically case conferencing between health service providers and correctional staff, is minimal and often inconsistent.

Recommendations are provided with a view to improving the delivery of correctional services in the province. The information in this document addresses the four deaths at the NLCCW and HMP and does not focus on any issues related to any of the other institutions within the province.

I. INTRODUCTION

The Adult Custody division of the Department of Justice and Public Safety is responsible for the health and safety of individuals who are incarcerated in correctional facilities. Managing mental health issues is particularly difficult in a correctional setting as there are high rates of mental health and substance abuse issues in the inmate population. The four people who died in custody all presented with varying levels of mental health and substance abuse issues which contributed to their deaths.

The Adult Custody division is responsible for male and female adult inmates serving sentences for less than two years and for those being held on remand. It also accommodates low risk federal offenders who stay in the province. There are five institutions including HMP and the NLCCW, which houses exclusively female offenders. In addition, there are two detention centres: The St. John's City Lockup and the Corner Brook Detention Centre (CBDC). The Superintendent of Prisons oversees all institutions in the province. Each institution is managed by an Assistant Superintendent who is responsible for operations.

Upon admission to all provincial correctional institutions, classification officers assess all inmates for security risk. The security assessment is used to determine institutional and security placement. Inmates are assigned a classification officer who assesses programming needs, counselling, risk for reoffending, and addresses other institutional requests. A correctional officer conducts a suicide assessment which evaluates suicide risk. The assessment includes self-reporting of previous suicide attempts and suicidal ideation, as well as mental pain. HMP and the NLCCW staff follow the policies for Adult Custody while standing orders (procedures) are specific to the institution.

The review was initially prompted by the death of Skye Martin at the NLCCW. The Office of the Chief Medical Examiner (OCME) determined that [redacted] s.40(1)

[redacted]

s.40(1)

[redacted] s.40(1) The Review Team was asked to review the circumstances around the death of Skye Martin and the mandate was later expanded to include the sudden deaths of three other inmates:

1. Douglas Neary – (HMP) on August 31, 2017;
2. Skye Martin – (NLCCW) on April 21, 2018;
3. Samantha Piercey – (NLCCW) on May 26, 2018; and
4. Christopher Sutton – (HMP) on June 30, 2018.

The Review Team spoke to family members, medical and correctional staff, and community service providers. All available documentation related to the criminal and medical history of the four individuals was considered. This included offender unit notes (OUN), contact notes, shift reports, assessments, and other documents, as well as security video surveillance from the facilities. The Review Team also considered external findings from the investigations and reports relating to the deaths of the four individuals produced by the Royal Newfoundland Constabulary (RNC), the Royal Canadian Mounted Police (RCMP), and the OCME. As well, the Review Team considered institutional documents such as standing orders and policies and legislation. Finally, the Review Team considered published reports and papers relating to best practices and to national and international standards within correctional facilities.

The circumstances surrounding the death of each of the four individuals are described in the following sections.

VI. ORGANIZATIONAL OBSERVATIONS AND RECOMMENDATIONS

During this review, the Review Team identified a number of themes which were brought to our attention through interviews, observations, and documents. It is important to discuss these as they play a role in the functioning of the organization. Many of the recommendations stem from systemic issues which impacted the lives of the four individuals. Without addressing these issues, similar outcomes for other inmates are likely to occur. Several of these themes were also identified by the *Decades of Darkness* report that also made recommendations for significant organizational change.

6.1 Her Majesty's Penitentiary

HMP was first opened in 1859 and is the largest provincial institution. It has been operating as an adult correctional institution for 159 years. HMP is a medium/maximum-designated provincial institution. It normally accommodates up to 170 inmates and up to 190 inmates on weekends when offenders serving intermittent sentences are accommodated. Although there have been some infrastructure updates since the *Decades of Darkness* report in 2008, the building remains dilapidated, overcrowded and in a constant state of disrepair.

At HMP, there are an average of 34 correctional officers scheduled to work on weekday day shifts and 24 correctional officers on weekend day shifts, and fewer on evenings/nights throughout the week and weekends. During the day, correctional staff conduct escorts and institutional transfers and take inmates to outside appointments. They also oversee recreation, visits and programming. After 1700 hrs the units are locked down because of minimal staffing and there is minimal access to programs and recreation for inmates.

Other staffing resources include:

- a full-time psychologist,

- two part-time psychiatrists (Dr. David Craig is one day a week and Dr. Jasbir Gill is two hours per week),
- a manager of institutional programs,
- one addictions counsellor,
- four classification officers,
- full and part time nurses,
- two nurse practitioners, one fulltime and one part-time; and
- one physician.

There are two examination rooms which are also used by medical staff as office space. There are other community-based service providers including the John Howard Society, pastoral care, Turnings, the CHMA Justice Program, and a part-time teacher. There is limited space to accommodate programming.

The institution has several living units including the East Wing Bottom, East Wing Top, West Wing, Unit 1 houses the Special Handling Unit (SHU) and Segregation. Inmates are also housed in Living Units 2, 3 and 4 and space for the intermittent inmates on the weekend which has also been used for women inmates when required.

6.2 Newfoundland and Labrador Correctional Centre for Women

The correctional facility located in Clarenville was opened in 1982 and initially housed male offenders. In 1996, it became the NLCCW when women were moved from a facility in Stephenville. It is a multi-security level facility which houses provincially-sentenced and remand female inmates. The institution can accommodate 26 inmates at full capacity, but has housed up to 40 inmates when necessary.

The daily staff complement includes three correctional officers and one lieutenant on each shift. There is an Assistant Superintendent and administrative support. There is a medical office which operates from 8am to 4pm and it is used to accommodate a contract psychiatrist (Dr. David Craig one day per month and telemedicine as required), a medical

doctor one day a week, and a nurse practitioner whose hours vary depending on need. There is a psychologist who provides 10 hours per week of individual counselling and Stella's Circle which provides seven hours per week of individual counselling and group programming. Inmates have daily access to recreation and adult education programs are also offered on a part-time basis. There is one classification officer assigned to the institution.

The facility consists of one range, which houses the inmates in general population. There is a Special Handling Unit commonly referred to as the Dissociation Unit, or Multi Placement Unit, and is used for disciplinary segregation, administrative segregation, and those on suicide precautions.

The current Assistant Superintendent is a member of a Federal/Provincial/Territorial group comprised of correctional leaders from across Canada who work with women inmates and who have signed on to the vision and guiding principles contained in a document called *Gender Responsiveness Corrections for Women in Canada*. The corrections system in Newfoundland and Labrador recognizes programs and services need to be developed and delivered based upon the needs of women. Assistant Superintendent Shelley Michelin reported up to 90% of inmates have addiction, substance abuse, and mental health issues. There also appears to be an increase in the complexity of mental health issues among inmates within the institution.

The NLCCW staff follow the policies for Adult Custody and the standing orders which are specific to the institution.

6.3 Legislation and Policy

The *Prison's Act,* RSNL 1990, c P-21 *and Regulations* provides for the governance and operation of the adult custody institutions in the province. It was passed in 1970 and there have been few substantive amendments since that time. It covers areas such as the role of the superintendent, the discipline of staff and inmates, and the security of the facility. In 2008, it was noted in the *Decades of Darkness* report that the legislation uses outdated

corrections terminology. It does not reflect a rehabilitative approach to managing inmates nor does it recognize nor protect the rights of inmates.

These issues were supposed to be addressed when the *Correctional Services Act* (CSA), was passed in the House of Assembly in 2011. It was anticipated the new act would be proclaimed later, once any practical changes resulting from the new law could be implemented. Such changes include drafting regulations, training of staff, and appointment of adjudicators. However, this new legislation was not proclaimed, and this means the outdated *Prison's Act* is still in effect. The CSA also includes a requirement for a statutory review which would have occurred in 2016 had the Act been proclaimed in the year it was passed.

A piecemeal approach has been used to update policy with some changes being more recent than others. For example, the policy on Disciplinary Segregation was recently reviewed and is currently being updated. The Review Team was advised many of the policies are not updated because they are waiting for the CSA to be proclaimed. Standing Orders, which govern daily operations such as security issues including escorts, counts and searches, are more current.

In addition to the importance of keeping policies and standing orders current, they must also be consistently enforced. It was observed and reported that policies and standing orders are often breached. Some of the breaches have become accepted practice such as when inmates cover cell windows. Policies exist for the safety and security of staff and inmates, and when not enforced, the breaches compromise the safety and security of inmates and the institutions.

Correctional best practice is constantly evolving in accordance with new standards and laws in areas such as human rights, segregation, conditions of confinement, and mental health. When policies and law become outdated or are not enforced, there is a gap between best practice and operational reality. The result is a lack of meaningful guidance that opens room for arbitrary decision-making, which is unfair to both staff and inmates.

When policies are ignored or outdated, it sends a message to staff that policies are peripheral to daily operations when they should be integral to every action and decision.

Recommendation 1

It is recommended the provincial government take immediate steps to proclaim the new Correctional Services Act and ensure all associated regulations and policies are updated.

6.4 Physical infrastructure

Senior Managers at both HMP and the NLCCW face many challenges managing the day-to-day operations of the institutions. In addition to health, safety and security of inmates, managers are responsible for other operational and corporate areas, including human resources, budgeting, information management, and training.

These challenges are more difficult for managers and staff working in an aging facility, which can inhibit implementation of modern correctional practices. For example, there is limited access to the outdoors, restricted inmate movement, and antiquated unit design. Areas such as the special handling unit are serving multiple purposes, including housing inmates with high safety and security risks together with inmates who are experiencing mental health issues. The lack of investment in modern facility is inhibiting progress in all operational areas which then impacts the well-being of staff and inmates.

The Review Team was advised that population management is complicated by overcrowding, staff shortages, and infrastructure deficiencies. Without appropriate space, it is difficult to manage incompatibility, intimidation, discipline, and mental health needs of inmates.

The Review Team has been advised inmates have been triple-bunked in cells that normally have two people and inmates have also been accommodated in non-cell areas such as gymnasiums. When the institutions exceed capacity, there is increased tension and conflict within the inmate population, leading to increased safety and security

concerns. In addition, there is pressure on existing services and programs resulting in inmates having less access to the programs that address their rehabilitation needs.

There have been many calls for a new institution over the years, and the Review Team encourages the government to continue to work on this as a solution. In addition, there are alternatives to incarceration. Other correctional jurisdictions have developed community-based alternatives that are designed to alleviate pressure in correctional facilities that are risk-based solutions, cost effective, and contribute to safe communities. In *Independent Review of Ontario Corrections* (2017) Howard Sapers also made recommendations around community-based alternatives to high remand population. He writes:

> "Decades of studies have consistently found that, when compared with serving a sentence in the community, sending someone to custody increases the likelihood that they will become re-involved in some form with the criminal justice system. The principle of restraint responds directly to these findings, prioritizing community supervision, programming and services, and requiring that incarceration be used as a last resort. (Sapers, 2017, 96)"

Recommendation 2

It is recommended alternative options to incarceration be developed for male and female offenders which could include: electronic monitoring, supervised bail verification, community based supervised housing and increased community supervised programs.

Recommendation 3

It is recommended that a new provincial correctional institution replace HMP and incorporate modern correctional design, dedicated space to address mental health housing and programming needs for both male and female offenders.

6.5 Human Resources

The Review Team was advised that there is an adequate number of correctional officers but that a consistently high usage of short-term sick time and long term disability contributes to high levels of overtime and regularly requires casual employees to meet staffing needs. As a result, shifts often remain unfilled because staff are not available to work. When staff are not available, the institution may be "locked down," meaning programs, recreation, and outside appointments can be cancelled.

The limited staffing complement for evenings and weekends creates additional operational challenges. Recreation and programs are limited during the off hours because of reduced correctional officer availability. Further when inmates present with health-related complaints during these periods, and when medical staff are not accessible, the Captain on duty is required to assess and prioritize which inmates have the highest need for external medical attention. The Captain has the responsibility of making health-related decisions for inmates and balancing staff assignments. When these circumstances arise, staff may not be available to immediately escort inmates and delay transportation to hospital. Another pressure on the weekends is the requirement for two correctional officers to transport and escort intermittent inmates to various pharmacies on the Northeast Avalon to access their prescriptions for methadone.

Insufficient staffing levels compromises the provision of services and the ability to maintain a safe environment and meet inmate rehabilitation needs. This many also contribute to low morale, and staff fatigue.

6.6 Training

A review of policy and standing orders for both HMP and the NLCCW was conducted to ascertain the mandatory training requirements for correctional officers, particularly in the areas of suicide intervention/prevention and first aid. Policy states: "All correctional officers will receive instruction in basic First Aid procedures and Mental Health Awareness procedures and will be required to maintain a minimum standard of proficiency in applying emergency techniques." The Review Team was provided with information pertaining to

completion of mandatory training in mental health and CPR/First Aid. In some cases, this information showed different completion rates for the same training. Results were contradictory, indicating training had occurred for some staff yet the documentation didn't support this assertion. In many cases, the certification had expired, or expiry dates were not recorded for training which was completed. For example, Mental Health First Aid training had a completion rate of only 4% and Road to Mental Readiness showed 29% and 34% completion. First Aid showed either a 41% or 54% completion rate.

Overall, the completion rates for required training is very low. This indicates the provision of training to correctional officers is not a priority. It is management's responsibility to ensure this training is completed and non-completion is a breach of Adult Custody policy. If training is not up to date, it contributes negatively to an officer's ability to properly respond to situations, especially in mental health-related situations.

In addition to the basic training provided upon employment, continued professional development is crucial as staff must be trained regularly to meet the ever-changing needs of the inmate population. The Review Team was advised at HMP, training is often cancelled or not scheduled because of staffing availability. In addition, there is minimal support and resources available to the management team to organize and schedule training.

Recommendation 4

It is recommended that Adult Custody ensure training is organized, completed, monitored and reported accurately.

6.7 Dynamic Security

Dynamic security is the primary form of security practiced by federal correctional institutions and at least five provincial jurisdictions. It is a security concept and a working method by which staff prioritize the creation and maintenance of everyday communication and interaction with inmates based on professional ethics. Correctional Services Canada (CSC) describes dynamic security as "regular and consistent interaction with inmates and

timely analysis of information and sharing through observation and communication. Dynamic security is the action that contributes to a safe working and living environment for staff and inmates and it is a key tool to assess an offender's adjustment and ability" (CSC Commissioner's Directive 560, Dynamic Security and Supervision). Examples of dynamic security include rapport building, training, networking, intelligence gathering and strategic analysis, which is best accomplished through direct supervision of inmates. Through a jurisdictional scan, the Review Team learned direct supervision is best practice in modern prison design and correctional operations.

There are elements of dynamic security practiced within Adult Custody, but it is limited. Closed control posts, or posts outside a locked unit, limit officer and inmate contact. Correctional officers do not always treat inmates respectfully and the general cultural attitude does not foster professional and friendly relationships with inmates. In addition, the Review Team was told that correctional officers who demonstrate empathy could be subject to ridicule by their co-workers. Some correctional officers are intimidated by inmates and they fear being manipulated if they build relationships and demonstrate compassion. The prevailing attitude is the least amount of contact with inmates the better. The physical design, staffing levels, and disrespectful and negative attitudes towards inmates contribute to this minimal interaction. Interviews with inmates and staff at the NLCCW provided a sense of a more positive relationship between staff and between staff and inmates. This is more consistent with dynamic security.

Dynamic security would improve staff and inmate interaction and would mean correctional officers have a regular presence on the unit. A dynamic security model can be implemented and accomplished without major infrastructure improvements.

Recommendation 5

It is recommended that a dynamic security model be implemented within all provincial correctional facilities.

6.8 Institutional Counts

Currently, institutional counts are conducted at regular hourly intervals except for a two-hour period at lunchtime. This regularly scheduled count is predictable and inmates know when a correctional officer will be present on the unit. Inmates can predict when the count will be done which creates opportunities for them to engage in activities in contravention of prison rules.

Recommendation 6

Institutional counts should occur at least hourly and at random intervals, which should be implemented immediately.

6.9 Drugs

The following information only pertains to HMP as the NLCCW does not experience the same level of drug-related security issues.

Drugs affect the safety and security of correctional institutions and controlling the movement of drugs is an issue for most institutions. The Review Team heard the drug problem has increased and is a major concern. Preventing drugs from entering HMP is increasingly difficult and the existing security measures are not sufficient to manage the growing problem. Illicit drugs continue to enter the institution by various means including [redacted] s.31(1)(a) s.31(1)(l) When drugs are present in the institution, the staff describe chaos as there are conflicts among inmates and the units are locked down as searches occur. Those who require medication for mental health issues are deprived of their proper treatment and are afraid to disclose to staff in fear of further repercussions.

The impact of illicit drug activity leads to an increase in assaults, threats of violence, and adverse health reactions to the drugs, which compromises the safety and security of inmates and staff. There is an absence of a focused strategy on drug interdiction. Dynamic security, a review of policies and procedures, and an investigation into modern technology, such as enhanced body scanners, are components of such a strategy. Other jurisdictions have introduced body scanners which have been very effective in the detection of drugs and other contraband on a person. A safe, drug-free institutional environment is fundamental to a well functioning institution and successful reintegration of inmates into society as law-abiding citizens.

Recommendation 7

It is recommended that a focused strategy to reduce drug abuse and trafficking within the institution be developed.

6.10 Communication and Information Management

During the review process, it was difficult to obtain complete file information and documentation. The electronic information management system known as PCOMS (Provincial Corrections Offender Management System) was not the sole repository of information. Information requests had to be retrieved from various staff who had files in their offices. On many occasions the Review Team had to request additional information it didn't know existed until it was referenced in documents.

It was also evident that the CCTV system was not well maintained as certain videos were destroyed, some videos had inaccurate timestamps, or had not been synchronized with other videos portraying the same incident.

Regular sharing of information is an issue between operational departments within the institutions. Informal discussions around individual cases are occurring but not in a consistent, coordinated case management approach. Correctional officers have a debriefing in the morning before shift change but not during the evening shift change.

Documentation regarding inmates is not always on PCOMS and therefore it is not accessible when required.

An assessment of the current system is needed as not all file information was entered in the electronic system. The quality of the file information was also inconsistent. This included the CCTV system.

Recommendation 8

It is recommended that information management practices are monitored for compliance with policy and for quality control.

Recommendation 9

It is recommended that in incidents of serious bodily harm or death, all CCTV videos will be archived in accordance with best practice standards to be determined by the Department of Justice and Public Safety.

6.11 Programming

Adult Custody is responsible for the provision of programming to inmates which are delivered using the services of both internal and external providers. There are several programs that are available to inmates to address substance abuse and other rehabilitation needs. However, there was no documentation or statistics provided to the Review Team that confirmed how often activities and programs are offered or whether these programs are beneficial, evidence-based, and result in positive outcomes.

Correctional staff told the Review Team that up to 80% of provincial inmates have substance abuse problems consistent with other Canadian jurisdictions. Canadian national prevalence data indicate at least 7 of 10 offenders in the federal correctional system have engaged in problematic use of alcohol and other drugs during the one-year period prior to their incarceration (Canadian Centre for Substance Abuse, 2004).

There is one addictions coordinator at HMP. Earlier this year, this position was left vacant for three months which meant that institutional based substance abuse programs were not offered during this period. The Review Team was advised that typically only 50% of inmates at HMP are getting access to programs. A factor affecting inmate access to programs is a security list that prohibits some offenders from attending group programming because of security concerns despite their needs. As a result, those inmates have little or no access to such programs. Based upon the level of substance abuse issues and the long wait lists, the program availability is not meeting the needs of the inmates. The Canadian Mental Health Association (CMHA) also provides services at HMP to sentenced inmates who have a diagnosed mental health disorder. Their services also extend upon release and assist the inmate within the community. The CMHA's services would be beneficial if expanded to include inmates on remand, subject to appropriate funding being provided to support this expansion.

There continues to be a challenge in having inmates access recreation, mostly due to staffing shortages, inmate compatibility issues and an outdated facility. Senior staff informed the Review Team that recreation is sometimes limited to once or twice a week, but HMP Standing Order 14 says "recreation will be divided into four one-hour groups daily." Due to increased incompatibility in the inmate population, there are more groups to be accommodated, so time and space time has become a larger issue. As an example, an inmate at the West Coast Correction Centre said during his year and a half incarceration at HMP, he only went outside for recreation about 10 times, and his mental health was affected by limited access to fresh air. In Stephenville, he has access to outside activities twice a day which has improved his mental health. Lack of access to recreation for inmates at the NLCCW was not identified as a concern.

The *Decades of Darkness* report also identified concerns with inmate access to recreation and leisure activities. The report stated:

> "Structured leisure activities usually involve physical activity and sports, but may also include arts and crafts, writing and music. These activities help inmates to develop a constructive use of their leisure time, to

> discover new interests and to set personal goals. Well-organized recreational activities help reduce tension and can benefit the overall atmosphere and mood of the prison (DOD, 2008, 130)".

Inmates at HMP must have more access to outside recreation and fresh air. For example, consideration should be given to the construction of temporary airing courts designed to allow more inmates access to outside.

Recommendation 10

It is recommended that recreation be provided to inmates for at least one hour per day as per standing orders.

According to the report *Gender Responsive Corrections for Women in Canada: The Road to Successful Reintegration (2017)*:

> "History has demonstrated that male-based correctional models present limitations for a smaller, diverse group of women with complex and unique needs. Presently, there has been a unanimous agreement amongst federal, provincial, territorial correctional authorities and stakeholders alike to do more than replicate a system designed for men".

In 2016-2017, Newfoundland and Labrador participated in a federal/provincial/territorial sub-committee dedicated to enhancing the interventions, programs, and services for women involved in the correctional system. The work of the sub-committee highlights the interaction of trauma/victimization, substance abuse, and complex mental health difficulties with the need for women-centred programming, interventions, and services. (CSC, Gender Responsive Corrections for Women in Canada: The Road to Successful Reintegration, 2017). The need for policies and programs that consider the specific need of female inmates was included as a principle in the province's *Correctional Services Act*

(s. 4) in 2011, which as noted above, is not implemented. The Review Team supports the need for a gender based strategy for female offenders.

At the NLCCW, most programs are offered through community-based organizations including Stella's Circle which provides seven hours a week of varied individual and group programming such as addictions, trauma, anger management, healthy relationships, and transition support to women being released to the community. The Review Team heard seven hours of weekly program offerings through Stella's Circle is not sufficient and there are limited other programs available.

Recommendation 11

It is recommended a program plan be developed that includes a needs based assessment for each offender designed to reduce criminal risk and which is regularly reviewed, and updated. Programs should be delivered to every inmate in a timely manner and outcomes recorded for evaluation purposes.

Recommendation 12

A female offender strategy be developed that is evidence-based and includes gender and trauma-informed interventions, programs, and services.

6.12 Mental Health Services

There is a high incidence of mental health and substance abuse issues in correctional institutions in Canada. According to a 2015 report by Corrections Canada (No. 357), more than 70% of federally incarcerated inmates suffered addiction and mental health issues. In its recent report on mental health prevalence for federally sentenced women, CSC (2018) reported 79.2% met criteria for a current mental disorder. In Newfoundland and Labrador, correctional staff reported a significant increase in the number of inmates presenting with mental health and substance abuse issues in the last 10 years. Both correctional and medical staff provided various estimates that 77% to 87% of inmates have either mental health issues, substance abuse issues, or both. There was no recorded statistics provided to the Review Team to confirm these rates.

The Review Team was advised inmates present with varying degrees of severity in relation to mental health problems and mental illness. The Review team was advised there is no mental health strategy, that incorporates a through assessment process, intervention and treatment, monitoring and quality control and training. During the admissions procedure inmates are assessed by corrections staff for suicide risk and by medical staff for health issues. Both assessments include questions regarding the inmate's mental health.

The medical assessment relies on inmates self-reporting their physical and mental health diagnosis and/or needs. If the inmate identifies a mental health issue, a referral can be made to a mental health professional. In the case of a repeat admission, staff can avail of correctional reports and health records to supplement the assessment.

The suicide assessment process includes the use of a screening tool referred to as the *Suicide Assessment,* which is completed upon admissions. The tool does not appear to be linked to the other mental health assessments and it is unclear how the information is shared and used by other staff. As this may be the only suicide assessment that is completed until an individual is seen by a medical professional, it is critical that this information be communicated to medical and correctional staff. The information identified through these assessments is valuable for correctional staff so they know how to address the needs of individuals upon admission to the facility. This information should be shared as part of a comprehensive and coordinated strategy to address mental health issues.

When an inmate discloses or when staff believe an inmate is experiencing a mental health crisis, including self-harm or risk of suicide, the inmate can be placed in administrative segregation for observation to ensure their personal safety, until they are seen by a medical professional. While under suicidal observation, inmates are monitored by CCTV, stripped of their clothing and given a suicide gown and a suicide blanket. If an inmate is placed on the unit for suicide observation, they must be seen by an institutional psychiatrist in accordance with Standing Orders, HMP 4.01 and the NLCCW 1-59. Once

assessed by a psychiatrist, a decision is made to release an inmate, to maintain their status on suicide observation or to transfer to the forensic unit of the Waterford Hospital for treatment.

Depending on the psychiatrist's work schedule, an inmate may not be seen for up to four days. The current practice may result in a gap between the crisis and access to a medical professional. The psychiatrists interviewed by the Review Team indicated that when an individual is admitted to the SHU and in serious mental health crisis, being segregated in a cell anywhere from hours to days while waiting to see a psychiatrist is not helpful to their mental health state and can worsen their condition. Further, the SHU houses inmates for reasons other than to address mental health issues and it is not a therapeutic environment for those suffering from a mental health crisis.

The response of correctional staff is focused on managing the immediate crisis. The immediate response is to manage behaviours including self-harm, suicide risk and safety due to incompatibility. It is evident there is limited mental health services to meet the needs of the populations in both institutions. Psychiatric and psychological services are limited in both institutions and the current allocation of positions is inadequate to meet the increasing mental health problems. Given the increase in mental health issues experienced by the inmate population, the current access to psychiatric services as well as the minimal treatment space within HMP and the NLCCW is not sufficient to properly treat inmates/patients. The types of treatment and supports received while incarcerated also impacts offender reintegration into the community and their general recovery (Mental Health Strategy for Corrections, 2016).

While a new institution will include space to alleviate the need to use segregation to accommodate inmates experiencing a mental health crisis, a more therapeutic environment with enhanced services cannot wait for construction of a new facility.

Recommendation 13

Space at HMP and the NLCCW, be repurposed, renovated or constructed as a mental health unit that is therapeutic, staffed with mental health professionals and correctional staff with enhanced mental health training.

Recommendation 14

Review present mental health professional staff allocations at both HMP and the NLCCW to ensure adequate services are available to each inmate.

Dr. Craig has been the primary psychiatrist for Adult Custody for almost 20 years. He acknowledged there is limited information sharing. He stated he does not regularly receive documentation from the Waterford Hospital when inmates are transferred back to Corrections. He said he may have seen patient release documentation once or twice during his career. Nurse practitioners in both institutions also stated there is limited documentation provided to the medical units except for a patient instruction note with a list of medications and follow up appointments. The Superintendent advised he has not seen discharge letters, and that limited documentation accompanies an inmate when they are released from the Waterford Hospital and returned to HMP or the NLCCW. Dr. Nazir Ladha, Forensic Psychiatrist at the Waterford Hospital, advised there is a discharge letter sent to the Superintendent relating to an inmate's diagnosis and treatment upon return to HMP and the NLCCW. Corrections staff reported they do not receive enough information to effectively manage mental health needs of inmates.

Another example of the lack of information sharing, exists between family physicians and psychiatrists upon admission. Inmates no longer have access to the same health care providers they did prior to incarceration. There is little or no consultation regarding diagnosis, therapy, or medications and this results in a disruption to the continuity of care. Such information is also not shared with care providers in the community upon an inmate's release.

The minimal information sharing between staff of health authorities and corrections is a systemic issue. These situations contribute to a lack of coordinated case management, creating a risk for inmates to fall through the cracks. This gap has been an issue, particularly between Adult Custody and the Waterford Hospital since at least 1991, when it was identified in Justice Reid's report of the review of the death of inmate Michael Simon Jr. In his report, Justice Reid said:

> "There is an abysmal lack of meaningful communication between the forensic psychiatry unit and the prisons administration on important aspects of inmates' mental health... And when Simon was returned to the prison, administrators were never notified and certainly not in a formal way of the state of his health. They had to assume he was fit because he was returned from the hospital".

Justice Reid also noted throughout his review that the lack of communication was the most significant weakness in the prison system. This situation continues to be prevalent and it negatively impacts the effective delivery of mental health services to inmates.

Adult Custody is responsible for the health of inmates during their incarceration. In other jurisdictions, including Nova Scotia, Alberta and British Columbia, the health authorities have taken on the responsibility of the provision of all health care services in the provincial institutions. This approach is expected to improve accountability and provide a higher level of continuity of care, quality health care, and more effective information sharing among health professionals. The Review Team is of the view that the expertise required to deliver effective mental health services exists within the health care sector and the approach implemented in other provinces would improve or resolve many of the systemic issue that have been identified.

Recommendation 15

That the Department of Justice and Public Safety and the Department of Health and Community Services implement a comprehensive mental health strategy which includes screening and assessment, management and intervention strategies, communication,

and training. Please refer to the CSC's April 2018 Suicide Prevention and Intervention Strategy.

Recommendation 16

That the Government of Newfoundland and Labrador consider transferring responsibility for the provision of all health care services within provincial correctional institutions to the Department of Health and Community Services.

Recommendation 17

The Review Team did not consider whether the treatment provided to the four individuals was in accordance with medical standards as this is beyond the scope of the review. It is therefore recommended that the mental health services provided to the four individuals be reviewed by appropriate members of the medical community.

VII. CONCLUSION OF REVIEW

The sudden deaths of the four individuals in custody is tragic and distressing for families and correctional staff. The Review Team was cognizant of this throughout the review process and approached interviews and the review of the personal information of the four individuals with respect and empathy.

The current system cannot adequately address mental health and addictions issues. Due to the extraordinary number of daily challenges and systemic problems that exist, the services and programming available are focused on addressing immediate or crisis issues. This prevents Adult Custody from keeping pace with best practices in modern corrections and takes the focus away from the overall well being of inmates. There is a disconnect between the various mental health services available to an individual before, during, and after incarceration. Offenders may be released without having participated in programs and services that are necessary for safe rehabilitation and reintegration into the community.

Most of the issues identified have existed for many years and have been identified by past reviews. Notably, the authors of *Decades of Darkness* reported on the entire corrections system in Newfoundland and Labrador and made 77 recommendations for change. Even with implementation of many of these recommendations, the changes did not go far enough to have a lasting impact. Moreover, the number of inmates presenting with substance abuse and mental health issues has increased since 2008 and continues to do so.

Identifying the major problems in the system is not difficult. Implementing organizational changes that are effective and lasting is more challenging and requires collaboration of all stakeholders including elected officials, employees, unions and the community. Addressing one or several areas without consideration of an overall mental health strategy may appear to be taking steps forward but will not result in systemic changes. The Department of Health and Community Services must lead the development and

delivery of a mental health strategy for corrections. While a new prison will facilitate many changes, there are improvements that can be made within the existing infrastructure that will improve the delivery of mental health services in the interim.

The review did not reveal any information that would lead to a conclusion that is inconsistent with the outcomes of the investigations by police and the Office of the Chief Medical Examiner. The Review Team cannot conclude any action or inaction by correctional staff would have prevented the deaths of the four individuals. However, during the review process, it became clear there are many systemic issues which contribute to an environment that does not adequately support the needs of inmates. Systemic issues that impact delivery of mental health services became a focus of most of the recommendations as all four individuals were experiencing varying degrees of mental health issues.

Successful rehabilitation and reintegration of offenders is an important component of a safe and secure community. In order to achieve this, significant investment will be required. The corrections system in this province has not been a priority and it has been under-resourced for so long, it has now reached a breaking point. The Government of Newfoundland and Labrador must act to make mental health and well being of inmates a priority. Without significant changes, it is unlikely that conditions will improve.

VIII. SUMMARY OF RECOMMENDATIONS

Recommendation 1

It is recommended that the provincial government take immediate steps to proclaim the new *Correctional Services Act* and ensure all associated regulations and policies are updated.

Recommendation 2

It is recommended alternative options to incarceration be developed for male and female offenders which could include: electronic monitoring, supervised bail verification, community based supervised housing and increased community supervised programs.

Recommendation 3

It is recommended that a new provincial correctional institution replace HMP and incorporate modern correctional design, dedicated space to address mental health housing and programming needs for both male and female offenders.

Recommendation 4

It is recommended that Adult Custody ensure training is organized, completed, monitored and reported accurately.

Recommendation 5

It is recommended that a dynamic security model be implemented within all provincial correctional facilities.

Recommendation 6

Institutional counts should occur at least hourly and at random intervals and this should be implemented immediately.

Recommendation 7

It is recommended that a focused strategy to reduce drug abuse and trafficking within the institution be developed.

Recommendation 8

It is recommended that information management practices are monitored for compliance with policy and for quality control.

Recommendation 9

It is recommended that in incidents of serious bodily harm or death, all CCTV videos will be archived in accordance with best practice standards to be determined by the Department of Justice and Public Safety.

Recommendation 10

It is recommended that recreation be provided to inmates for at least one hour per day as per standing orders.

Recommendation 11

It is recommended a program plan be developed that includes a needs based assessment for each offender designed to reduce criminal risk and which is regularly reviewed and updated. Programs should be delivered to every inmate in a timely manner and outcomes recorded for evaluation purposes.

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INTERVIEWS

Corrections, Health & Other Government

Dr. Simon Avis, Chief Medical Examiner Newfoundland and Labrador

Owen Brophy, Retired Superintendent of Adult Corrections

Dr. Mark Brannan, Physician NLCCW

Brian Budden, Nurse Practitioner HMP

Cathy Connors, Classification

Dr. David Craig, Psychiatrist for Adult Corrections

Neil Croke, Director of Security for Corrections

Gerri Dalton, Nurse Practitioner HMP

Derrick Elliott, Psychologist NLCCW

Diana Gibbons, Assistant Superintendent, HMP

Dr. Jasbir Gill, HMP Psychiatrist

Dr. Chris Goodall, Physician HMP

Susan Green, Program Coordinator, HMP

Captain Scott Guinchard, HMP

Darleen Kelly, Classification

Dr. Nazir Ladha, Forensic Psychiatrist Waterford Hospital

Captain Frank Lee, HMP

Sam Martin, Psychologist HMP

Shelley Michelin, Assistant Superintendent, NLCCW

CO David Murray, Classification

Don Roche, Superintendent of Adult Corrections

Kelly Rowsell, Assistant Superintendent, Bishop Falls Correctional Center

Captain Trent Sharp, Corner Brook Detention Center

Trudy Smith, Administrator, Newfoundland and Labrador Youth Center, Whitbourne

Lindsay Walker, Nurse Practitioner NLCCW

Cindy Whitten, Classification

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Heather Yetman, Program Coordinator Adult Corrections (past)

Dr. Neil Young, Clinical Chief Mental Health and Addictions

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CO J Bradbury

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CO J Cooze

CO A Daniels

CO D Dawe

CO S Donahue

CO B Hicks

CO D Hobbs

CO N Jones

CO S Lahey

CO N Marsh

CO M Nolan

CO J O'Neil

CO M O'Neil

CO K Osbourne-Earle

CO D Quinton

CO C Rogers

CO K Senior

CO B Shutts

CO S Vardy

CO M Wade

CO G Weir

CO B Whelan

CO D Wilkinson

CO V Young

Lt S Butt

Lt. T Cardwell

Community

Lisa Browne, Stella's Circle

Heidi Edgar, Canadian Mental Health Association

Barry Fleming, Office of the Citizens Representative

Denise Hillier, Stella's Circle

Dan McGettigan, Turnings

Kim MacKay, Human Rights Commission

Cindy Murphy, John Howard Society

Senator Kim Pate, Senate of Canada

Amelia Reinhart, Cultural Support Friendship Center

John Scoville, Superintendent NS Corrections

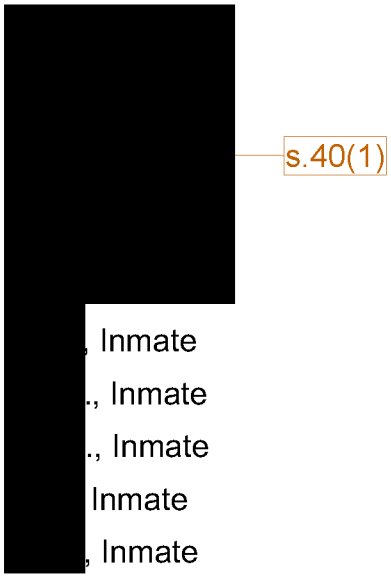
Len Davies, NB Corrections

Allen Curley, PEI Corrections

Ed Klassen, Manitoba Corrections

Jennifer Wheatley, Director General, Mental Health, CSC

Family and Personal Connections



REVIEW TEAM BIOGRAPHIES

MARLENE JESSO is a Retired Superintendent with more than 34 years of policing experience with the Royal Newfoundland Constabulary. She has held numerous positions and ranks in the RNC in areas such as Street Patrol, Labrador West Detachment, and the Criminal Investigation Division where she investigated serious assaults, sudden deaths, and the possession and trafficking of illicit drugs. She was the Officer in Charge (OIC) of the Professional Standards Unit in relation to internal reviews and Public Complaints against police officers. She was also the OIC in charge of the Training section that provided ongoing training and professional development for police officers and the RNC recruit program.

Before retirement, she held the position of OIC of the Combined Forces Special Enforcement Unit (CFSEU-NL) a joint forces unit with the RNC and RCMP whose mandate was the investigation, dismantling, and disruption of drugs and organized crime in the province. She has certification in Major Case Management Team Commanders Course, Critical Incident Commanders Course, and Drug /Clandestine Lab Investigation Courses from the Canadian Police College and Ontario Police College as well as numerous leadership courses. She has held many roles in the RNC such as Critical Incident Commander, Crisis Negotiator, and Guard Commander.

In June 2016, she was appointed to the Federal Government's Task Force on the Legalization and Strict Regulations of Cannabis giving recommendations to the federal government in all areas of legalization. She has been a recipient of the RNC Exemplary Service Medal and the Queen's Jubilee medal. She has been a leader in the RNC and the community for many years until her retirement in May 2017.

MICHELLE HAWCO is a registered social worker and has experience in leadership, consulting, change management and client support in both the public and private sectors. Her career has focused on corrections management including work with the province of Newfoundland and Labrador and almost 20 years in multiple roles within Correctional Services Canada including Parole Officer, Program Officer, Deputy Warden and Area Director. Michelle has worked extensively in planning and managing services to support women offenders.

More recently, Michelle has taken on leadership positions in the area of Child Welfare and Child and Youth Care, both with the provincial government, the community, and with the Sheshatshiu Innu First Nation and the Shushepeshipan Ishpitentamun Mitshuap Inc with Innu in Labrador.

Michelle was awarded a Bachelor of Arts Degree in Psychology and a Bachelor of Social Work from Memorial University of Newfoundland. She is currently working towards her Master of Arts in Leadership at Royal Roads University.

She has volunteered with many organizations over the years including Iris Kirby House in St. John's and the Ishtar Transition Housing Society, a women's support organization

in British Columbia. She is currently a member of the School Council at Holy Spirit High School and a board member with the Manuel's Natural Heritage Society.

ROBERT ST. CROIX has spent over 32 years in law enforcement. He retired from the Royal Newfoundland Constabulary in 2014 at the rank of Sergeant. Robert has served in various divisions within the RNC including Patrol Operations, Professional Standards and Labrador West Detachment; however, he spent the majority of his career as a member of the Criminal Investigation Division, primarily as a Major Crimes Investigator where he investigated serious assaults and sudden deaths.

Robert has certification in Major Crime Investigative Techniques and Major Case Management from the Canadian Police College and Ontario Police College. He is a recipient of the Police Exemplary Service Medal and Queen's Jubilee Medal. Since his retirement, he has worked with the Town of Conception Bay South Enforcement Unit and as a panel member with the RNC Promotional Board.